PHYSICIAN ASSESSMENT & PERMISSION

--To be completed by Physician—

Client's Name: _____ Date of Birth:_____

Diagnosis:

Primary: _____ Date of Onset: _____

Secondary: _____ Date of Onset: _____

Other: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

_____

_____

Medications: _____

_____

Seizures: _____ No _____ Yes Type: _____ Date of last seizure: _____

Shunts/Implants: _____

Mobility: Independent Ambulation: _____ Yes _____No Assisting Devices _____

_____

In order to safely provide this service, CCMTRC, requests that you please note that the following conditions may suggest precautions and contraindications to equestrian activities. Therefore, when completing this form, please indicate whether these conditions are present, and to what degree.

Orthopedic

Atlantoaxial Instability- include neurological symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Joint Fusion/Fixation
Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt
Seizures
Spina Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

Other

Indwelling Catheters/Medical Equipment
Medication- ie. Photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological

Allergies

Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medial conditions (ie: RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorders

Client's Name: _____

As thoroughly as possible, please indicate current or past difficulties/symptoms in the following systems/areas that apply, including surgeries.

Area	No	YES	Degree/Comments
Auditory			
Visual			
Speech			
Tactile/Sensory			
Cardiac			
Circulatory			
Pulmonary			
Integumentary/Skin			
Immunity			
Neurologic			
Muscular			
Orthopedic			
Bowel/Bladder			
Learning Disabilities			
Cognitive			
Emotional/Psychological			
Behavior			
Other			

For those with Down Syndrome

An Atlantoxial x-ray and annual exam to exclude Atlantoxial instability is required for clients with Down Syndrome over the age of 3.

Date of X-ray: _____ Results: _____

Neurologic Symptoms of Atlantoxial instability: _____

Given the above diagnosis and medical information, this person is not medically precluded from participation in supervised equestrian activities. I understand that CCMTRC will weigh the medical information indicated above against any existing precautions and/or contraindications before accepting this person for therapeutic horseback riding lessons. Therefore, I refer this person to CCMTRC for ongoing evaluation to determine eligibility for participation.

Name/Title : _____ MD, DO, NP, PA OTHER: _____

Signature: _____ Date:_____

Address: _____

Phone: _____ License/ UPIN Number: _____